

Fifty-six Countries Later: Global Ideas for a Healthy U.S.

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Aims

- Put key health status indicators for the US in comparative perspective
- Briefly examine health disparities in the US, against some comparators
- Review selected US health systems indicators, with some comparisons with other countries
- Highlight examples of lessons from other countries that might assist in strengthening the US health system and enhancing health status in the US
- Examine how some of those lessons can be put into place, even in the face of substantial cultural, historic, and political constraints

My Arrival in the Philippines, 1966



Perspective

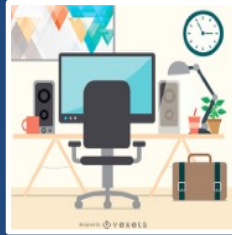
The Goal of a Health System:

To maximize the health of the population, in fairly distributed ways, at least cost



Tobacco Control

Substantial
improvements in
environmental and
occupational health



Improvements in
Automobile safety

Reductions in cancer
death rates



Expansion in
approaches
to disability

Some Good News

Yet We lag badly in
a number of
fundamentals

Some
Less



We spend more as a share of national income on health than any other country

We spend more in absolute amounts per person than almost any other country



We live shorter and less healthy lives than people in other countries that spend less

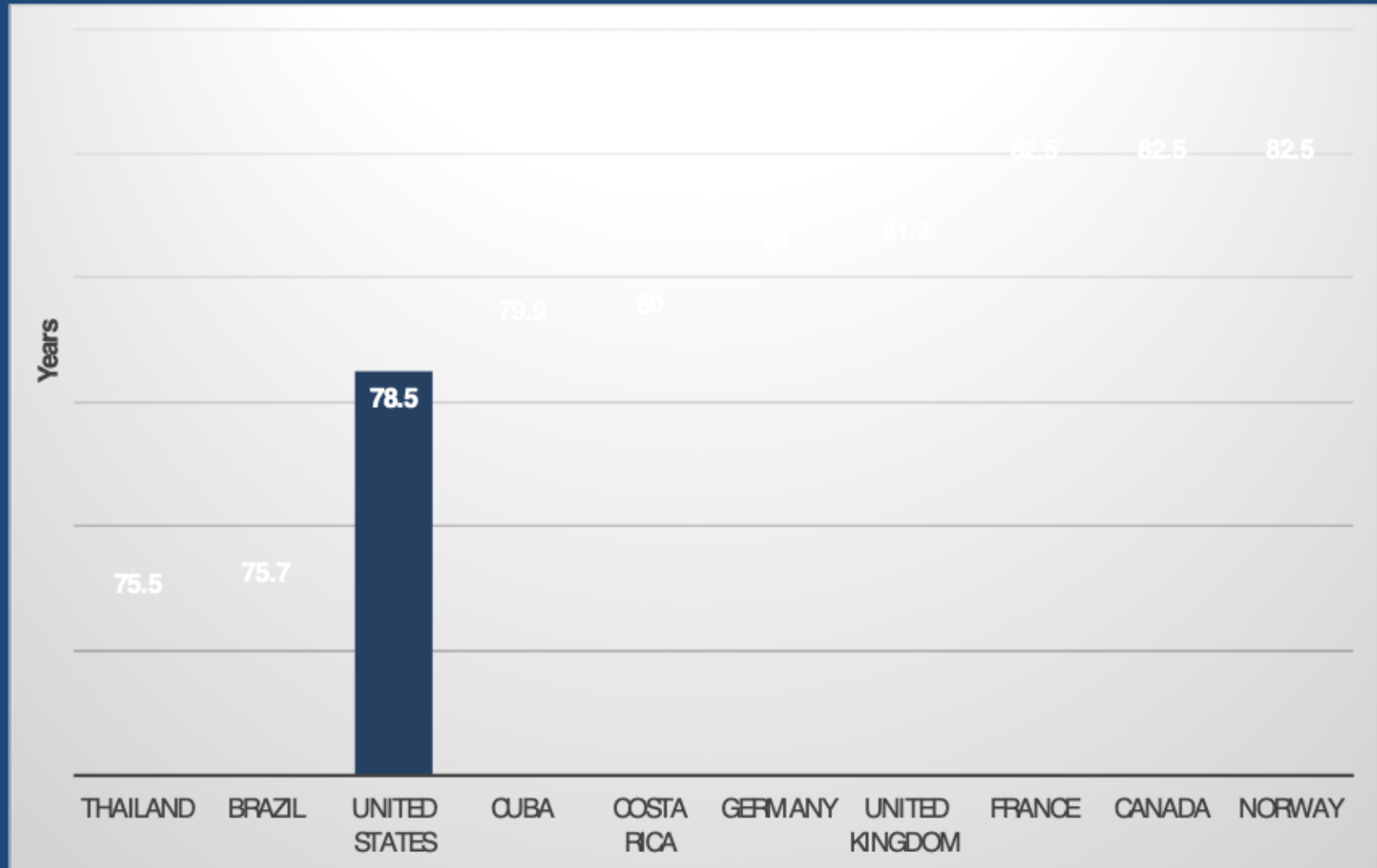
We have unacceptable health disparities



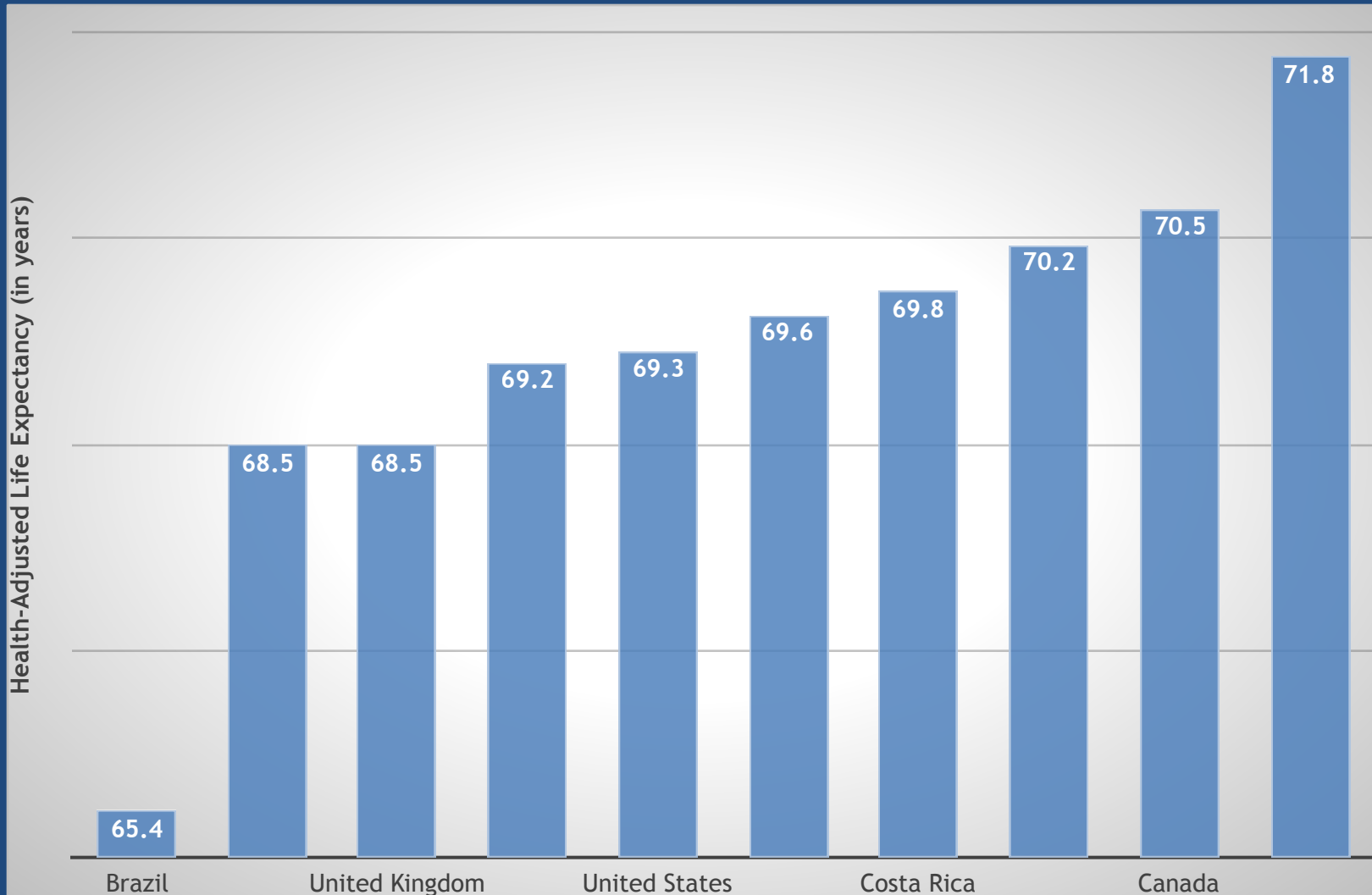
We face enormous disparities in the quality of care

HEALTH STATUS INDICATORS

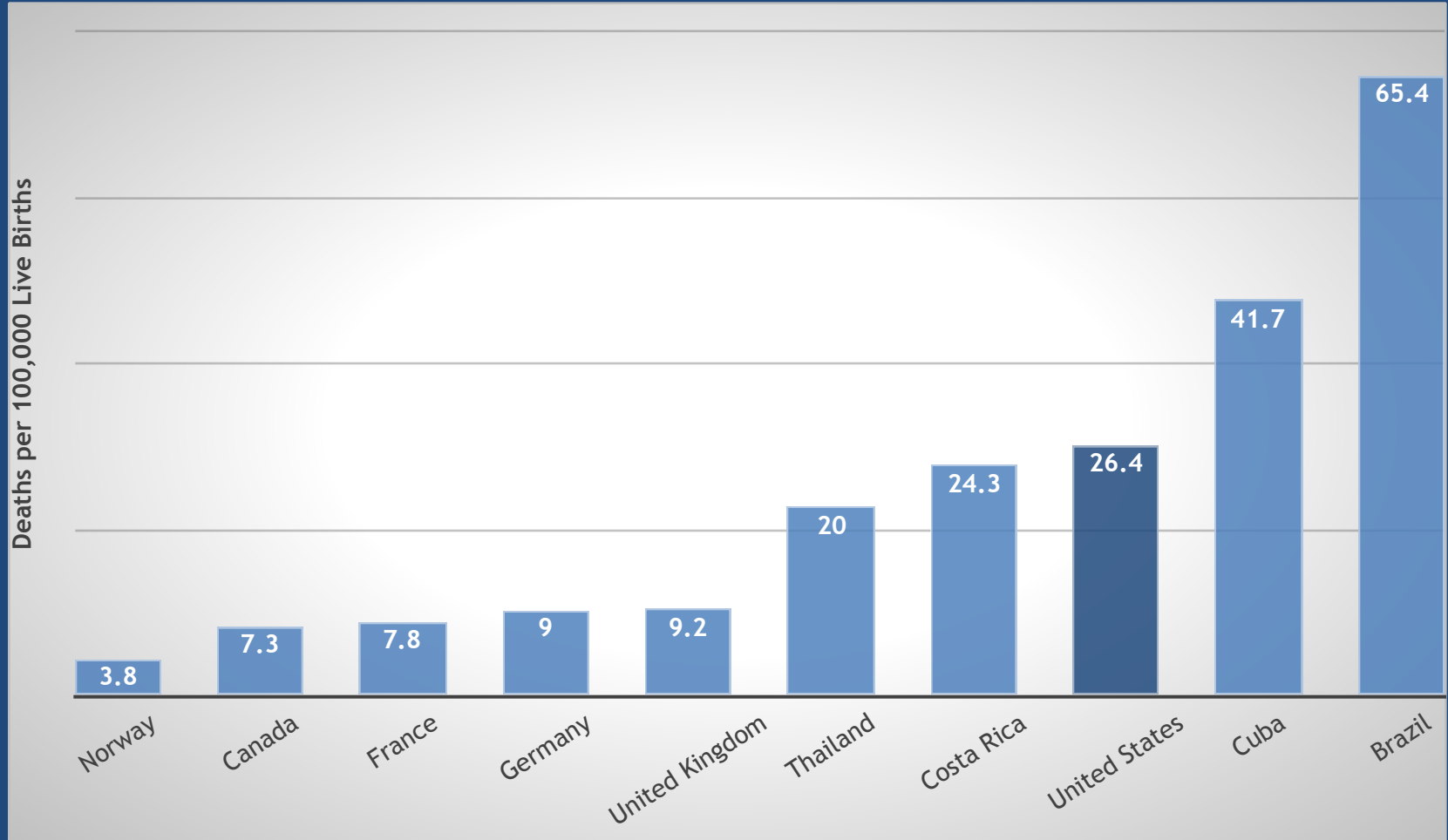
Life Expectancy, 2017



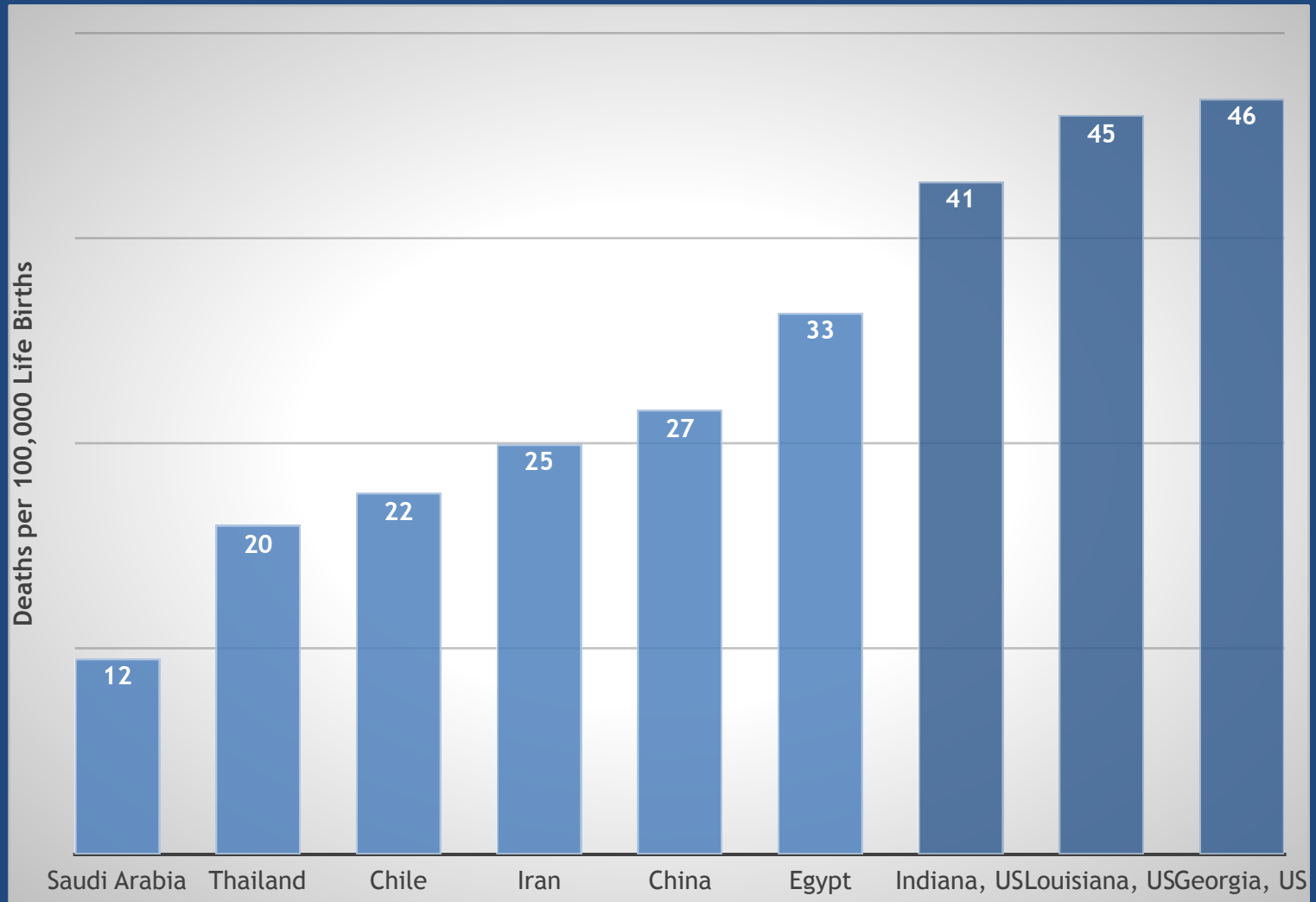
Health-Adjusted Life Expectancy, 2017



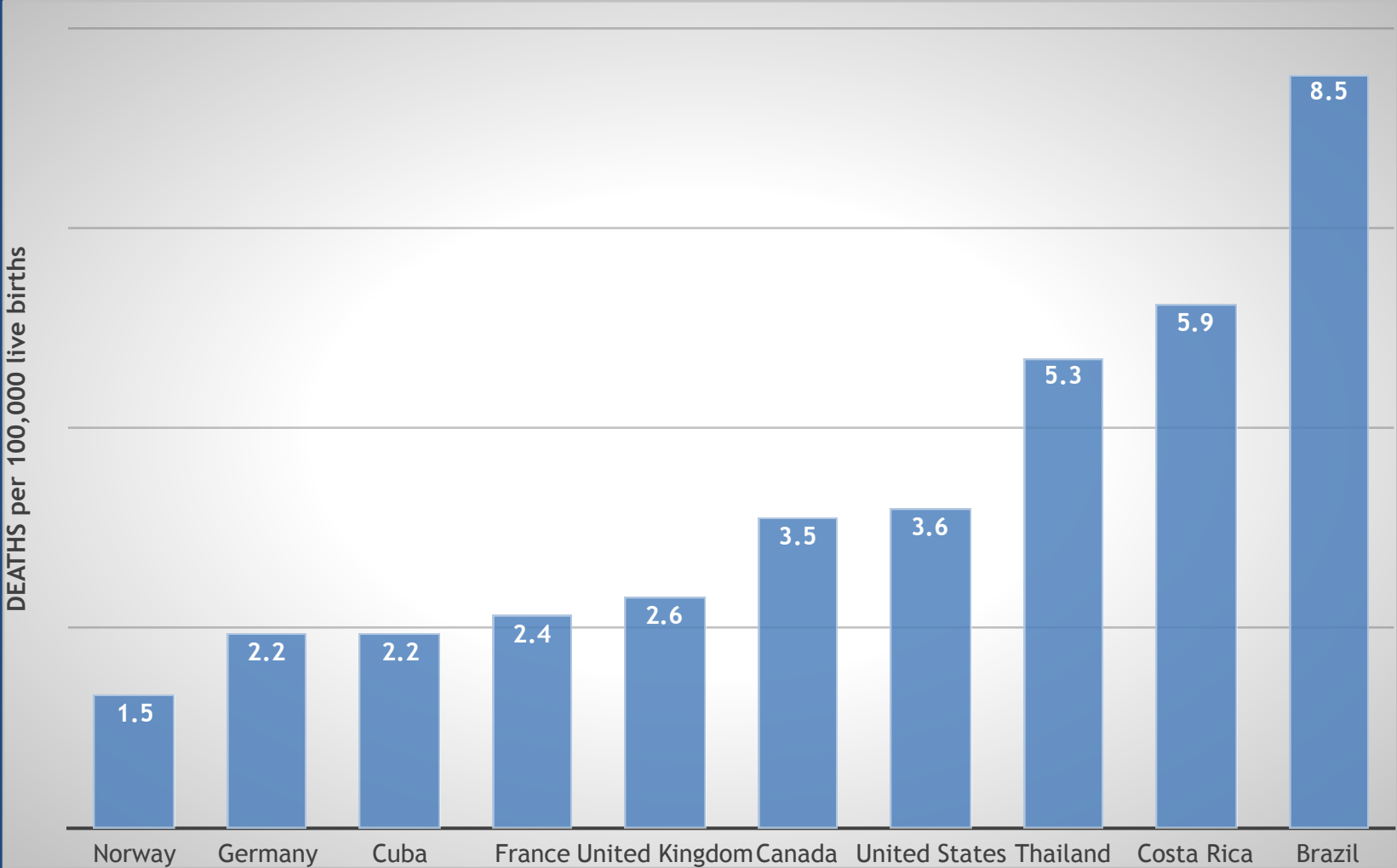
Maternal Mortality Ratio, 2015



Maternal Mortality Ratio: How Some US States Compare Internationally, 2015, 2018

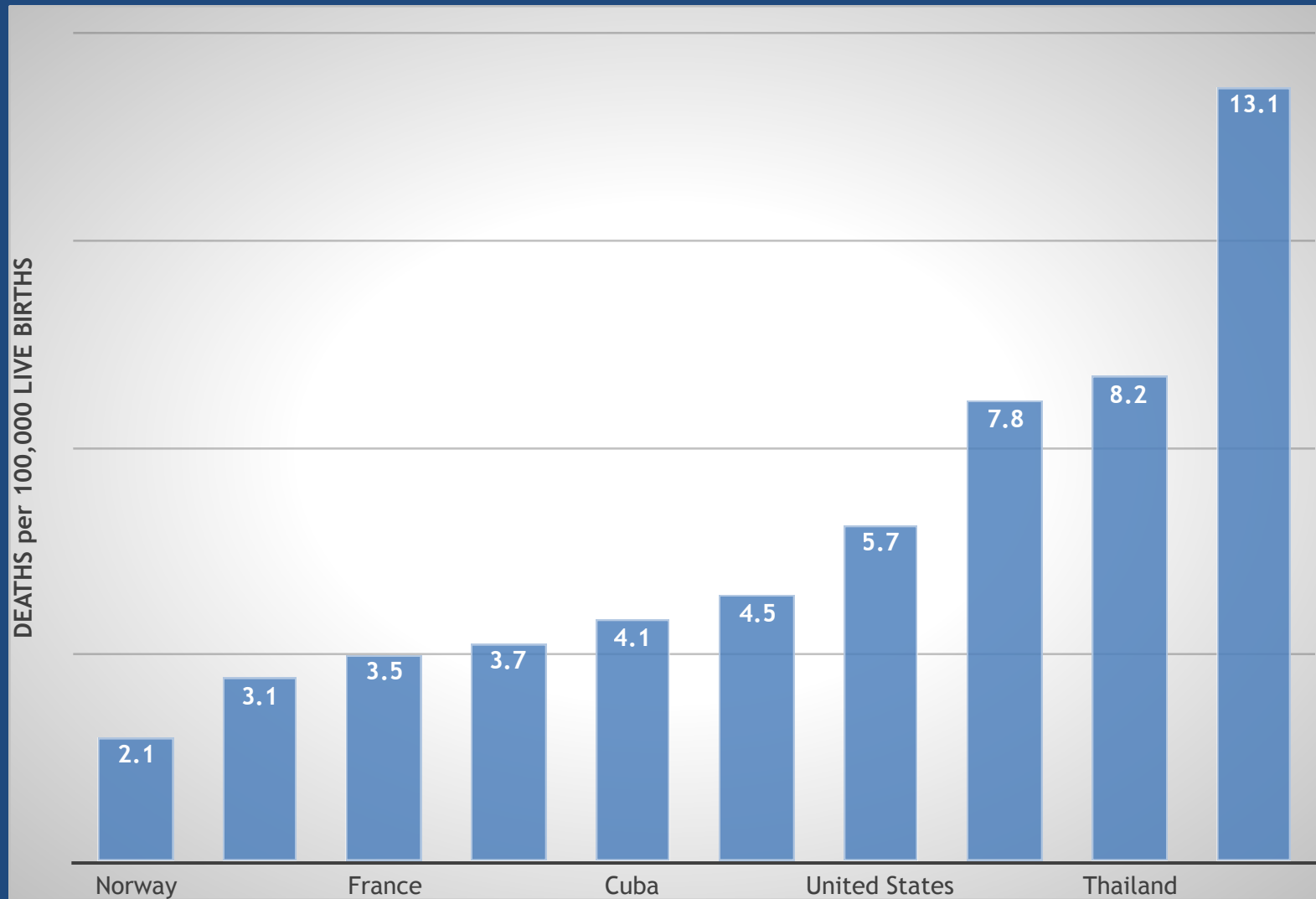


Neonatal Mortality Rate, 2017

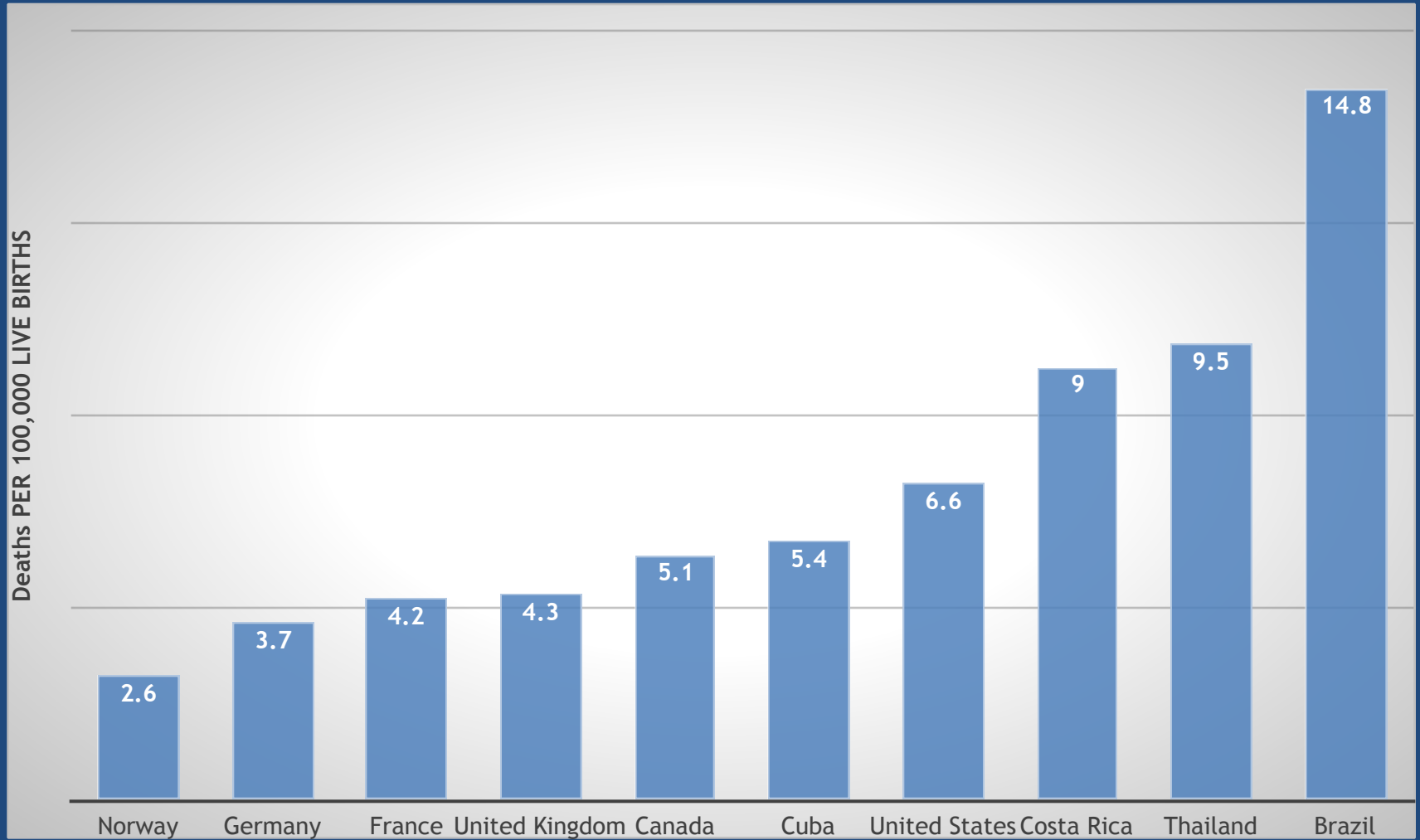


Source: World Bank Data. Neonatal Mortality Ratio (national estimate, per 100,000 live births). Accessed Feb 24, 2019. Retrieved from: https://data.worldbank.org/indicator/sh.dyn.nmr1year_high_desc=false

Infant Mortality Rate, 2017

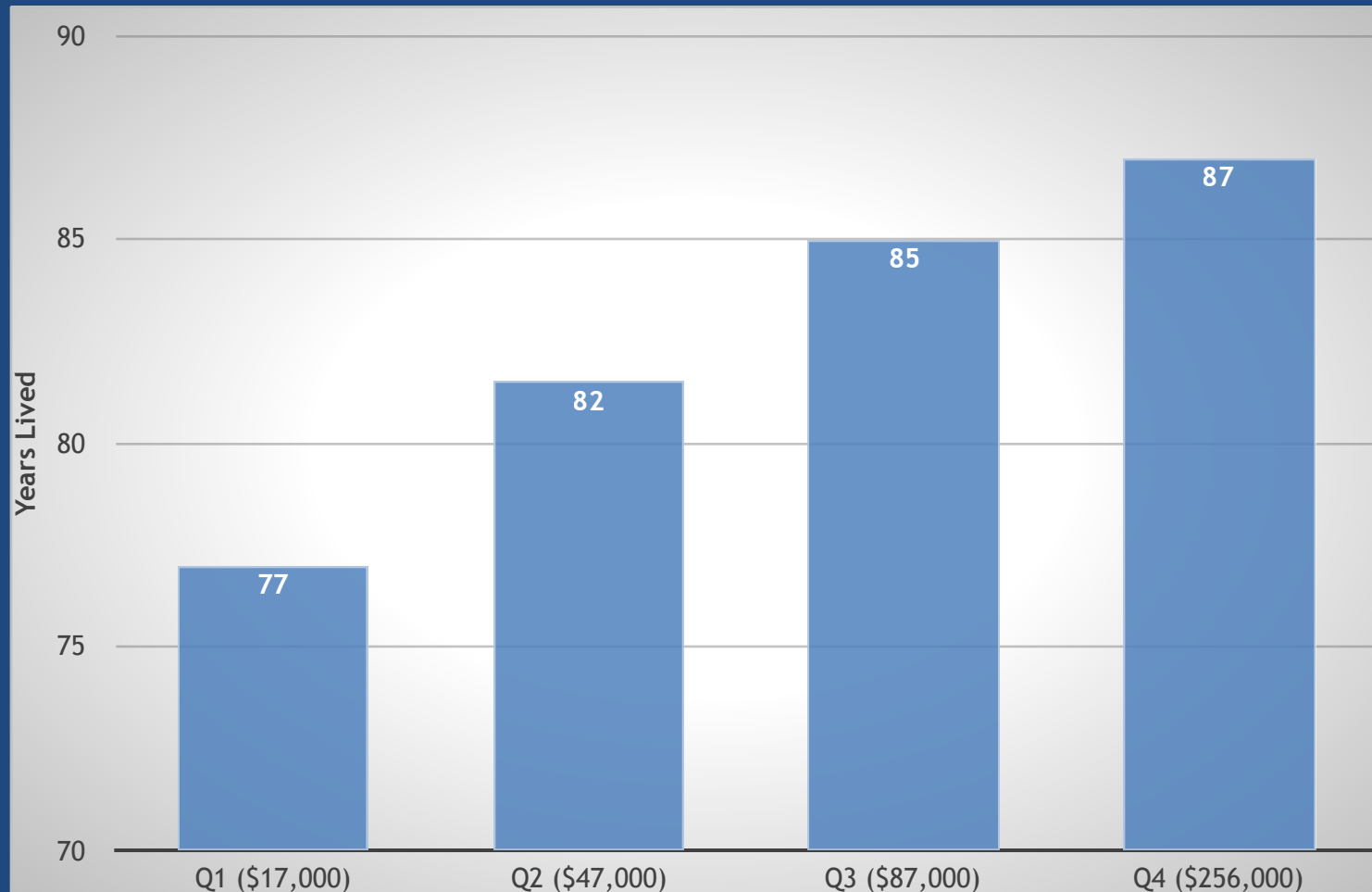


Under-5 Mortality Rate, 2017

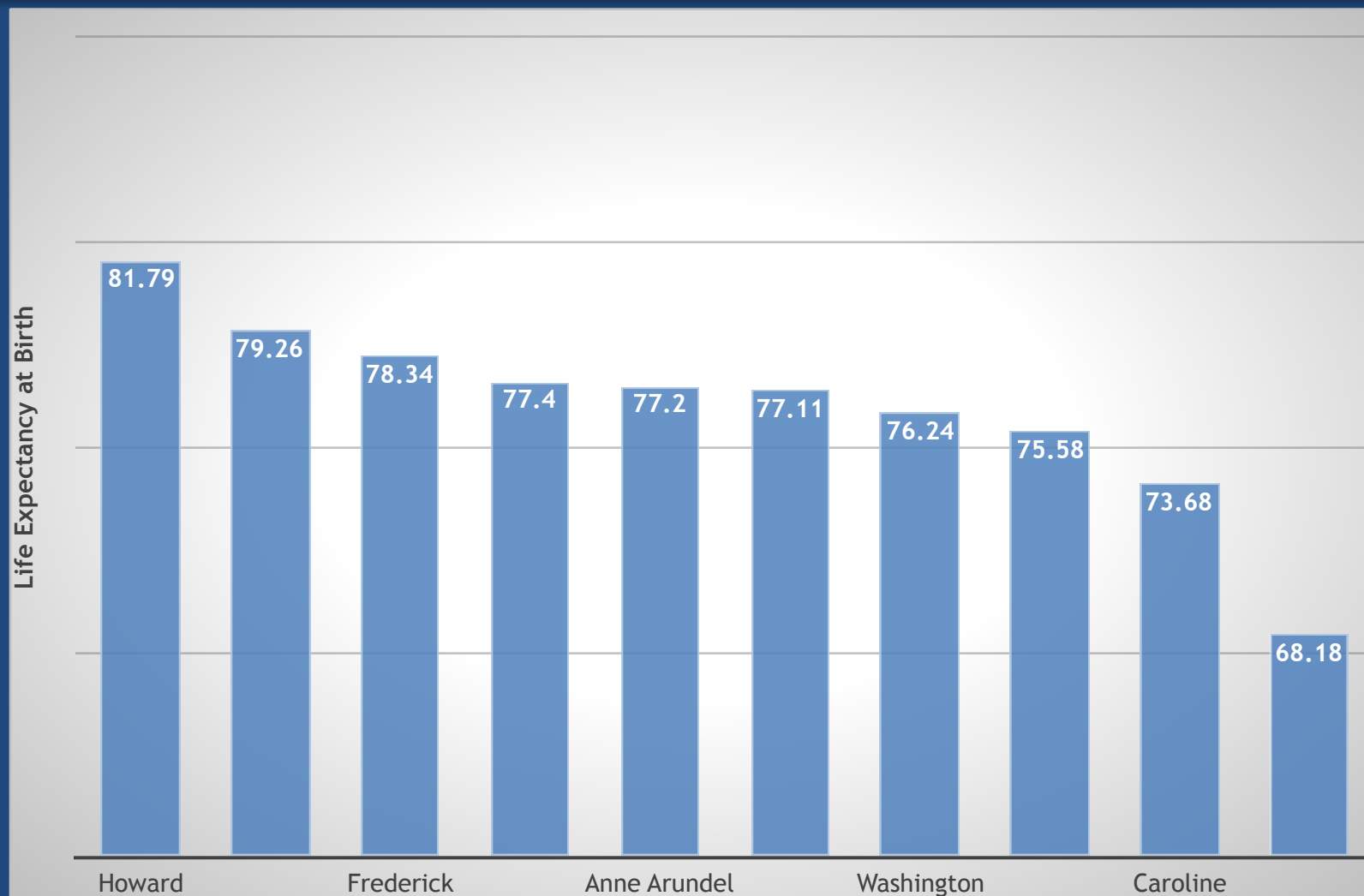


SELECTED HEALTH DISPARITIES

Life Expectancy Across Income Quartiles: US, 2015

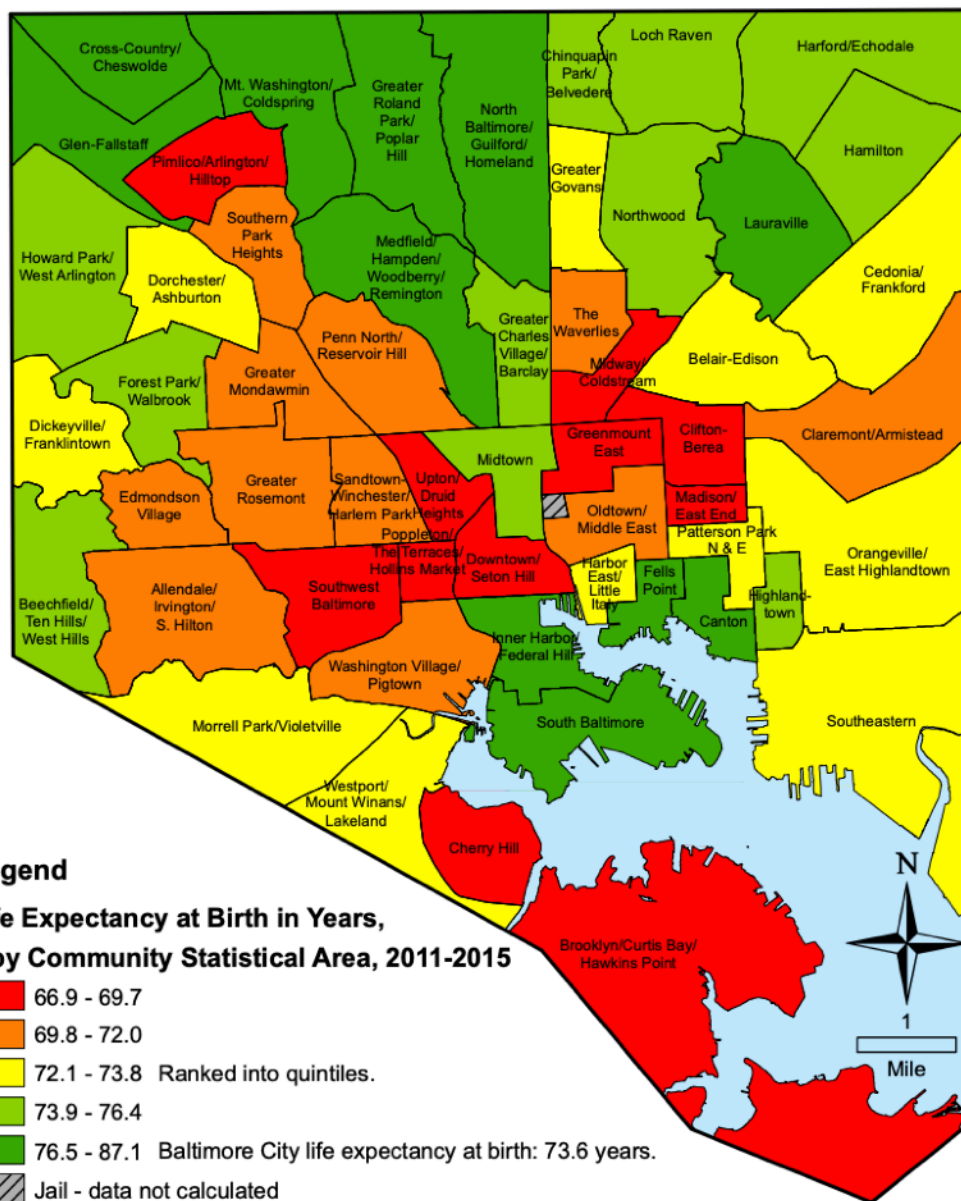


Health Equity: Male Life Expectancy, by County, Maryland, 2016



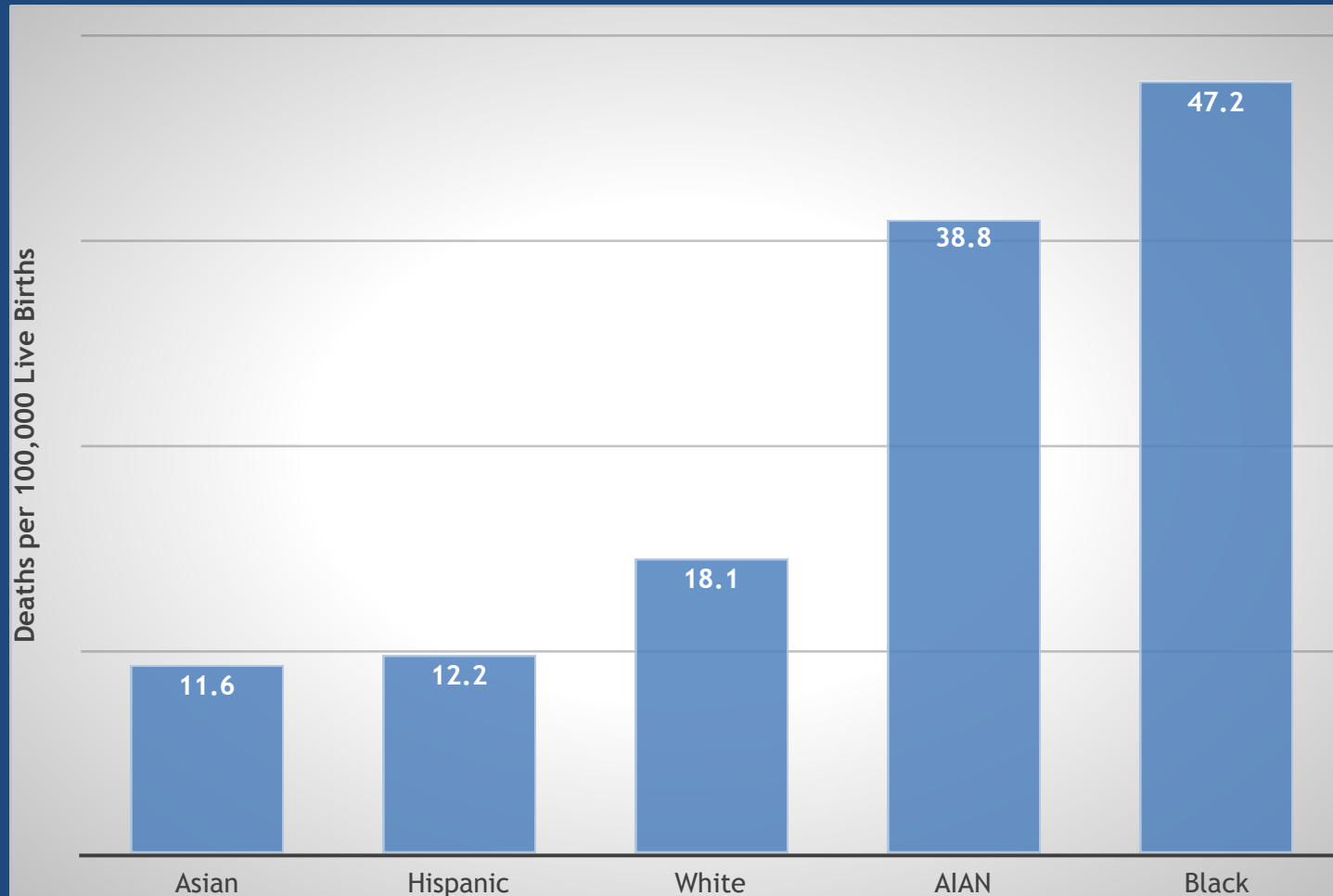
Health Equity: Life Expectancy by Neighborhood, Baltimore, 2011-2015

Life Expectancy at Birth in Years, Baltimore City, 2011-2015



Prepared by the Office of Epidemiology Services, Baltimore City Health Department, January 2018. BCHD calculations of data from the Maryland Department of Health, Vital Statistics Administration.

Maternal Mortality by Ethnicity in US, 2018



Infant Mortality Rate, Selected States, 2016

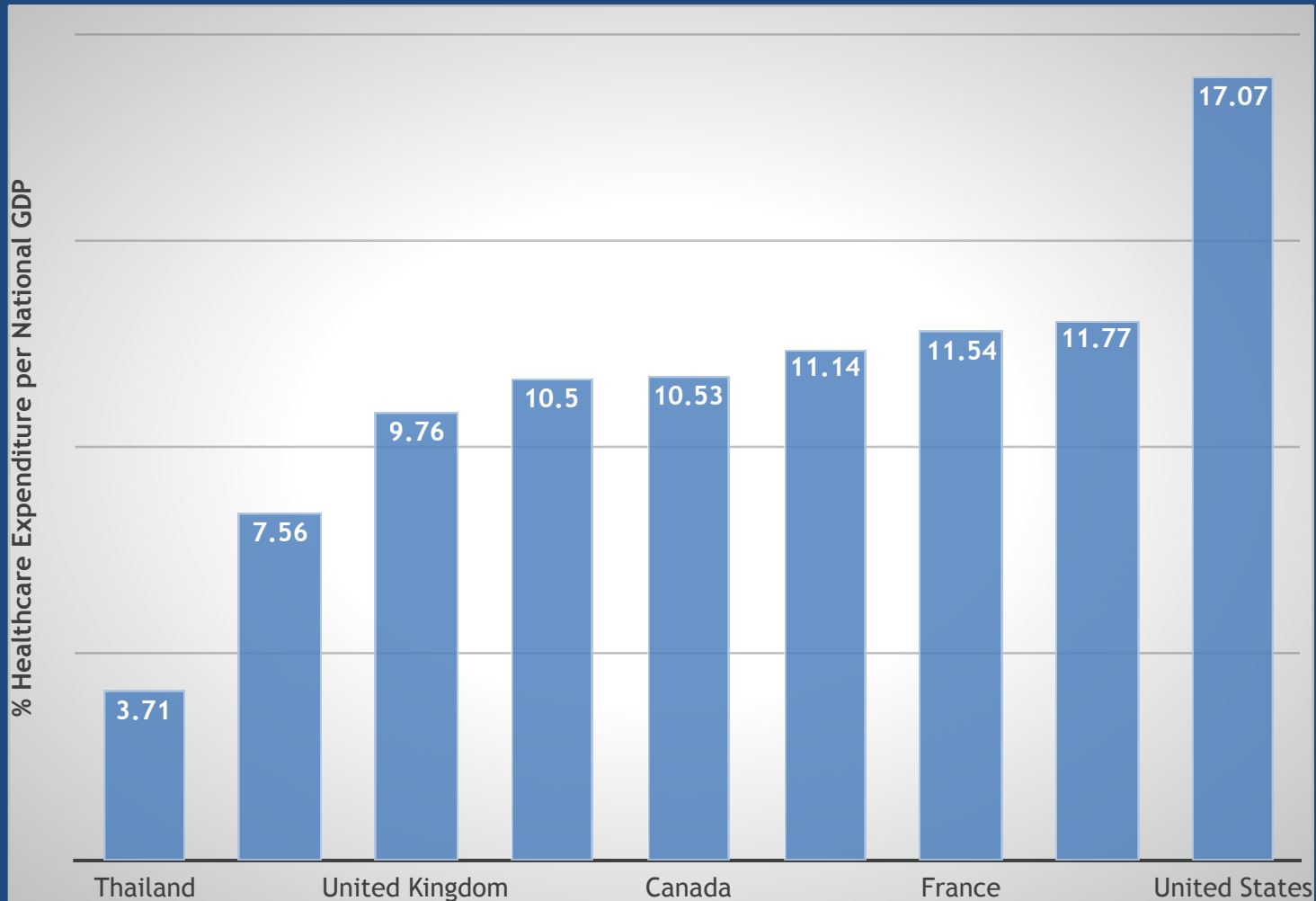
US State-Level Infant Mortality Rates (Deaths per 1,000 Live Births)

State	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic
Massachusetts	6.0	2.89	6.95	5.46
Iowa	3.9	5.09	12.95	7.49
Washington	4.3	4.07	6.69	4.11
Wisconsin	6.3	5.47	14.60	4.31
Oklahoma	7.5	6.13	14.42	5.83
Mississippi	8.7	7.01	11.20	Not sufficient data

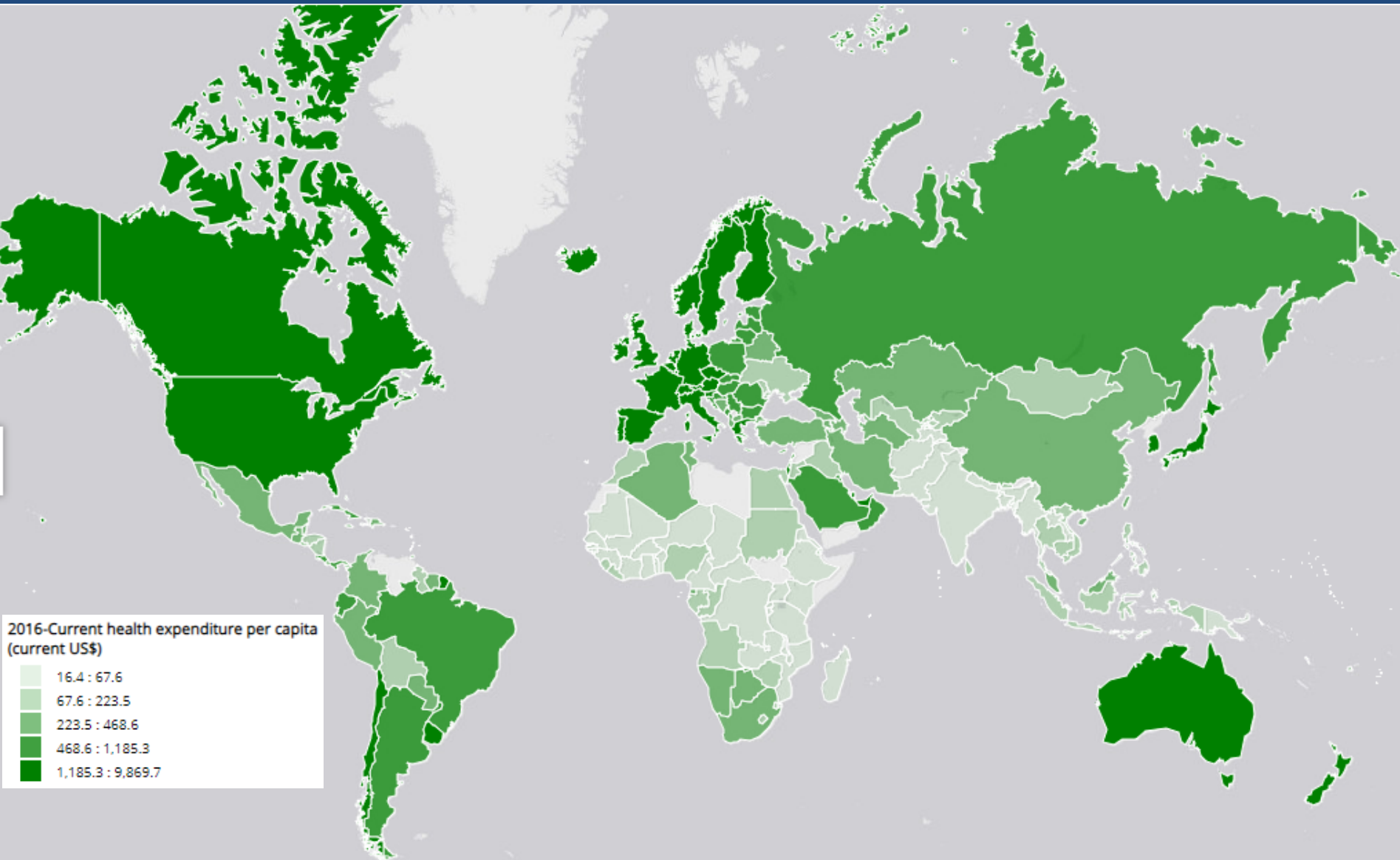
HEALTH SYSTEMS INDICATORS:

How does the U.S. compare?

Health Expenditure as Share of GDP, 2016

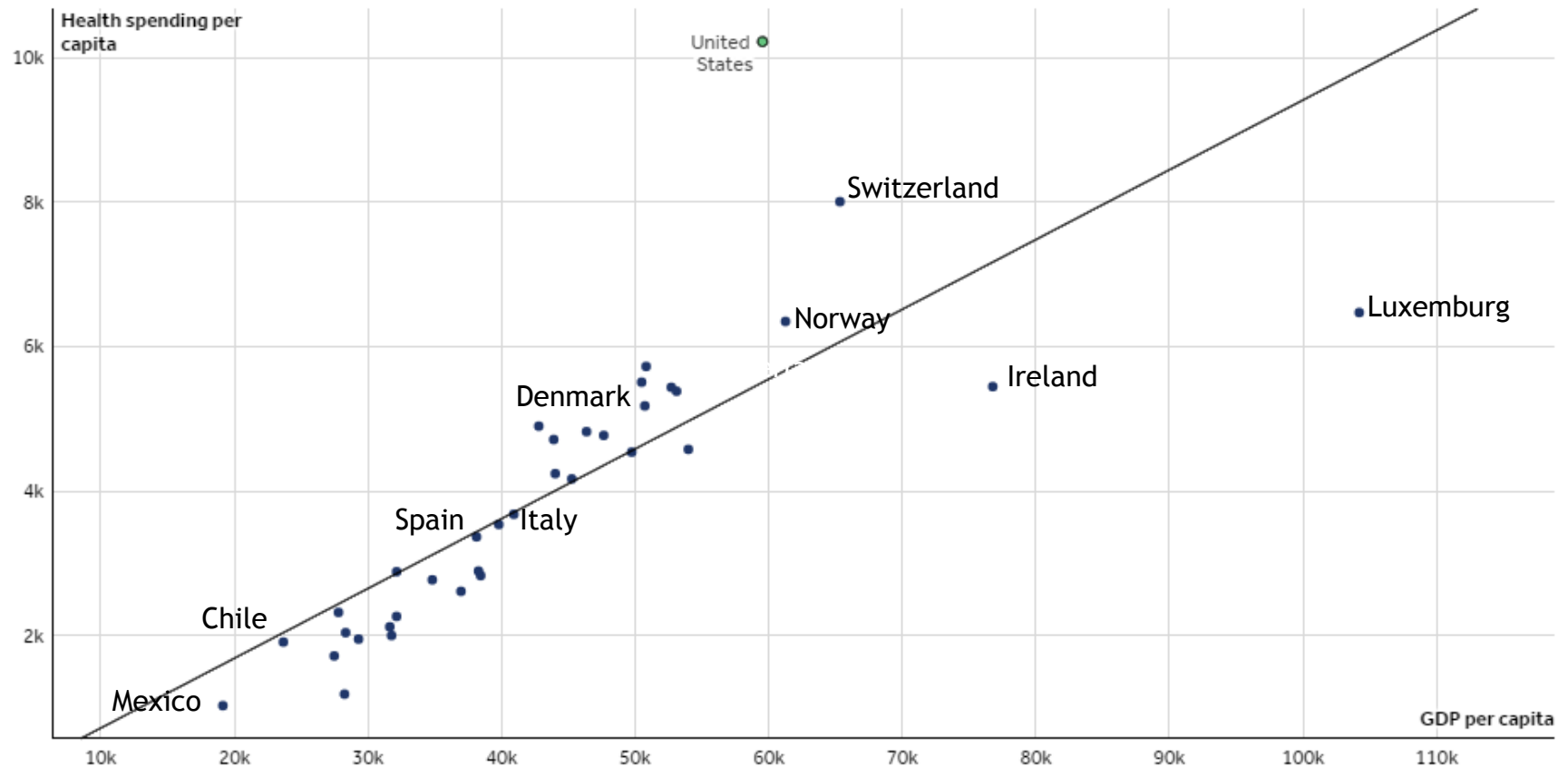


Health Expenditure Per Capita, 2016



Per Capita Health Expenditure Compared to GDP Per Capita, 2017

GDP per capita and health consumption spending per capita, 2017 (U.S. dollars, PPP adjusted)

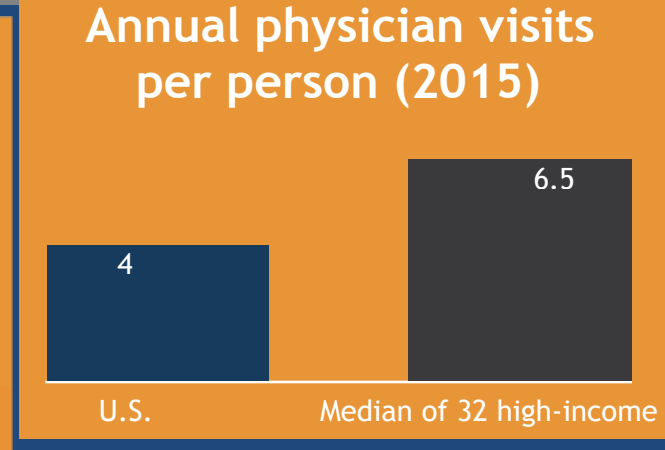
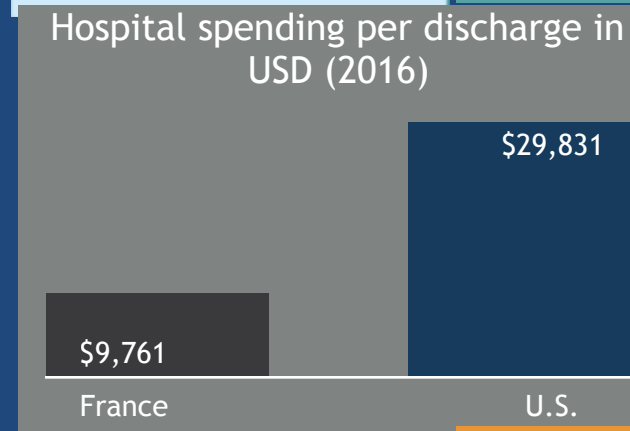
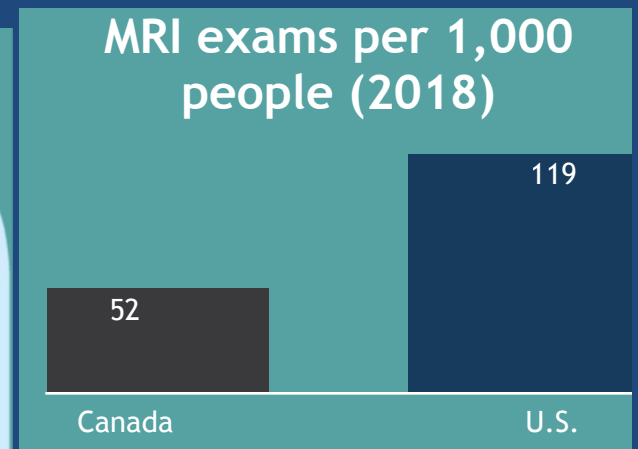


Source: KFF analysis of data from National Health Expenditure Accounts and OECD • Get the data • PNG

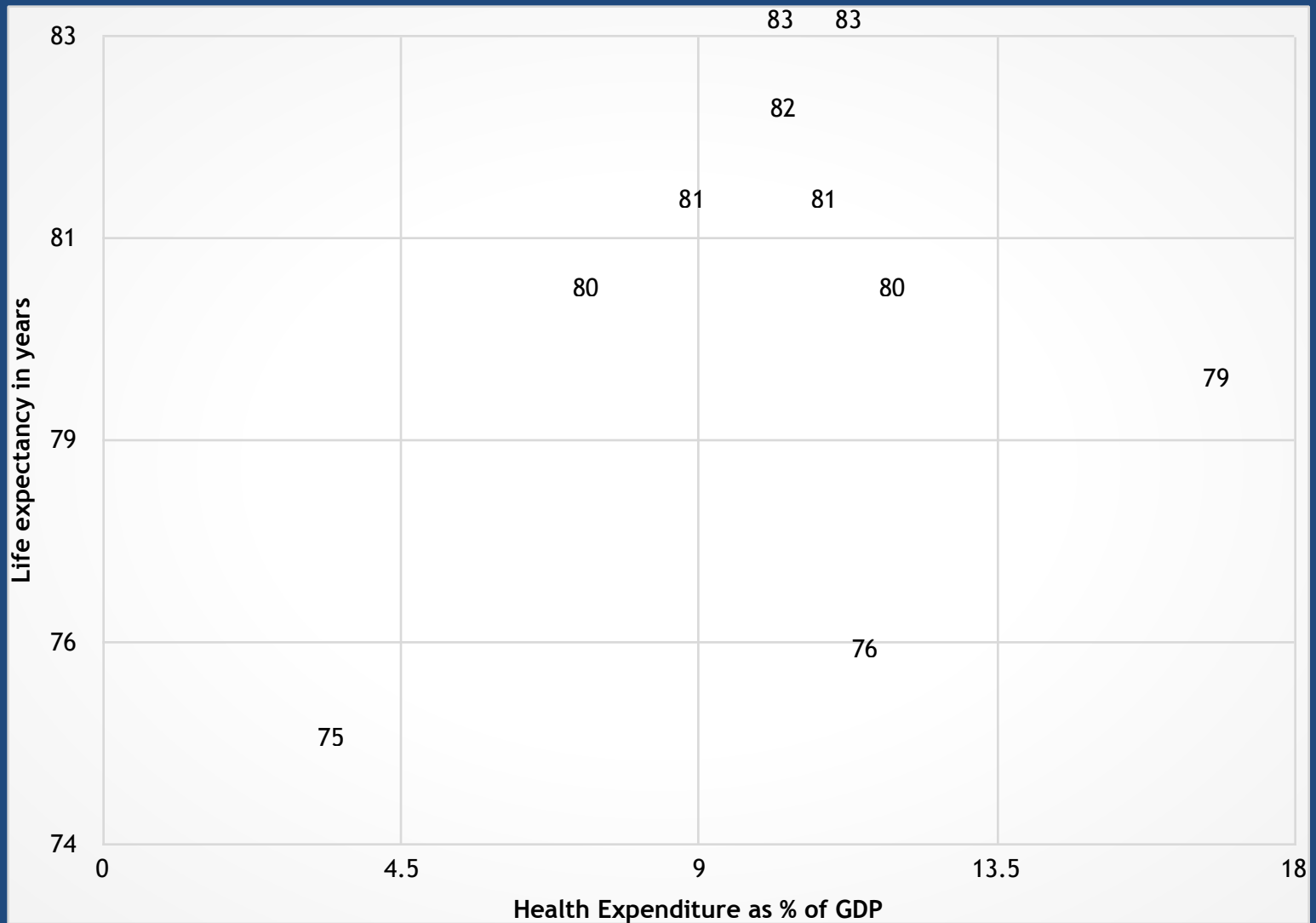
Peterson-Kaiser
Health System Tracker

National Income on Health

Higher healthcare spending is largely a result of higher prices for *technology and health care services*, rather than more frequent doctor visits.



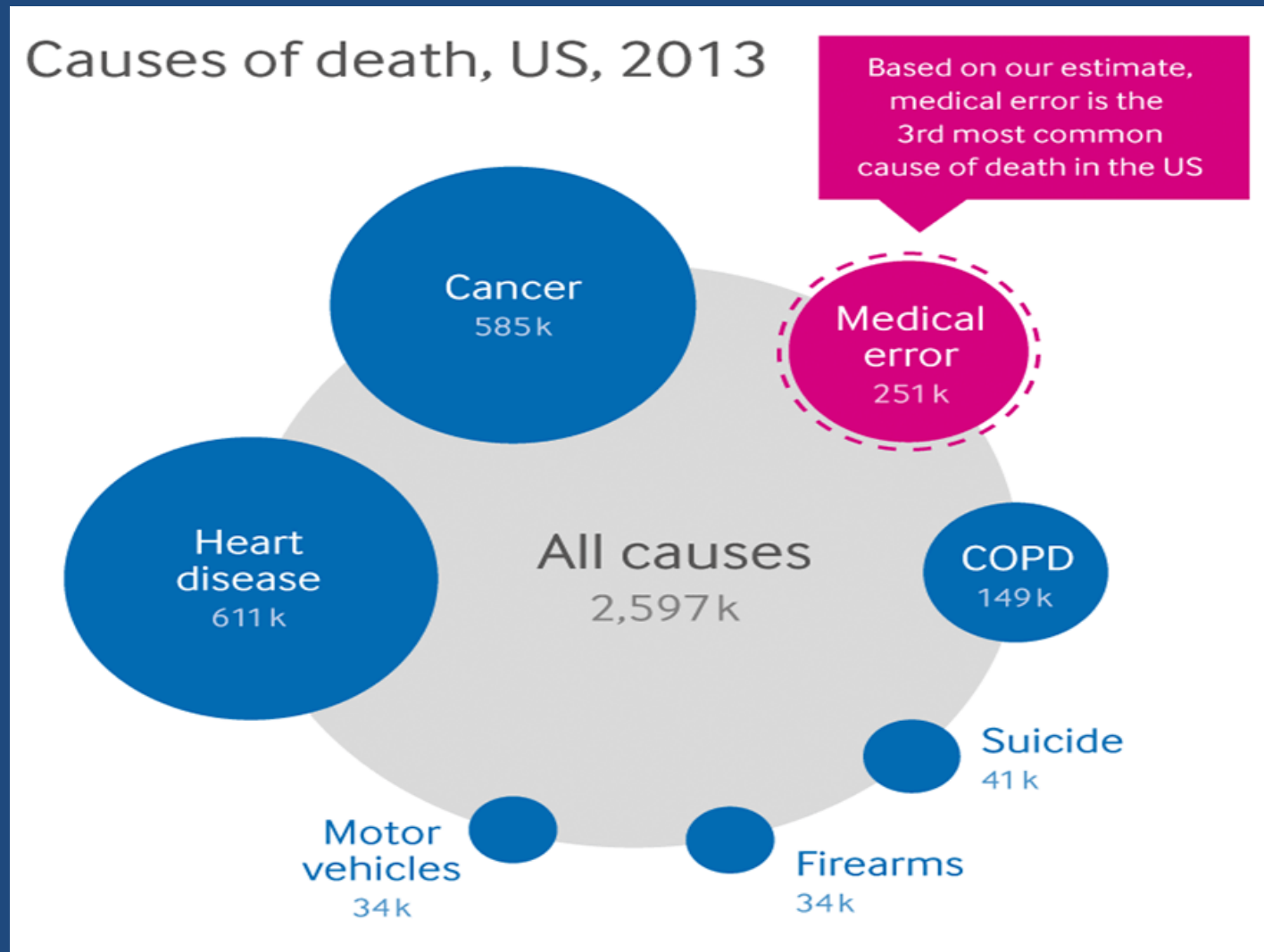
Life Expectancy vs. Health Expenditure (% of GDP), 2017



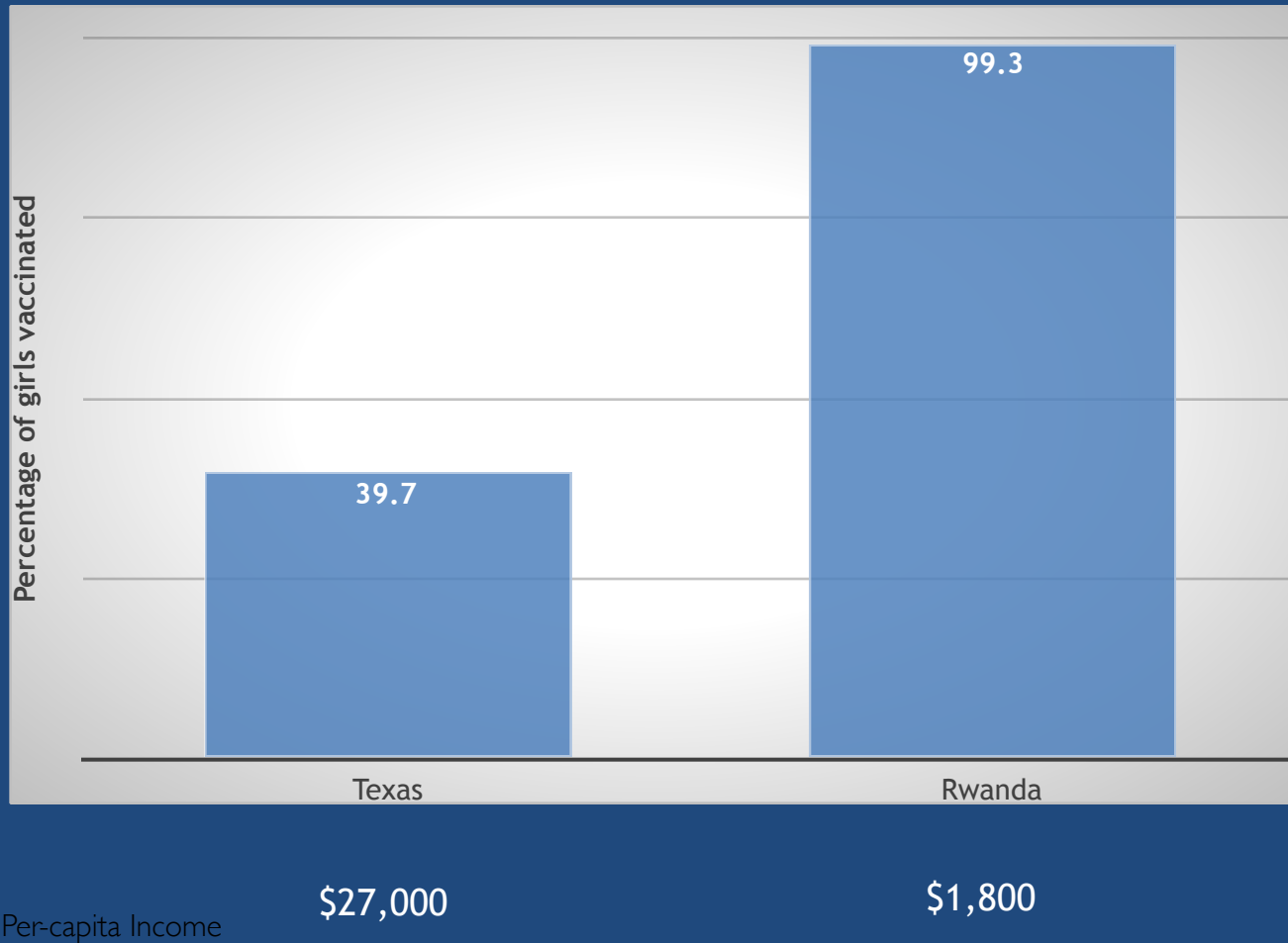
Insurance Coverage in the US in 2017

- **8.8 percent of people (28.5 million)** did not have health insurance at any point during the year, which was not statistically different from 2016 (8.8 percent or 28.1 million).
- The percentage of people with health insurance coverage for all or part of 2017 was **91.2 percent**, again not statistically different from the rate in 2016 (91.2 percent).
- Between 2016 and 2017, the number of people with health insurance coverage increased by 2.3 million, up to 294.6 million.
- In 2017, private health insurance coverage continued to be more prevalent than government coverage, at 67.2 percent and 37.7 percent, respectively.

Deaths from Medical Error



HPV Vaccination Rates for Girls: Texas vs. Rwanda, 2018



Source: Nehme E, Patel D, et al. Missed Opportunity: Human Papillomavirus in Texas. The University of Texas System Office of Health Affairs. Accessed March 16, 2018, from <https://www.utssystem.edu/sites/default/files/news/assets/HPV%20ins%20Texas%20Report.pdf>.

Republic of Rwanda Ministry of Health. "Rwanda to Eradicate Cervical Cancer by 2020." Accessed March 16, 2018, from http://www.moh.gov.rw/index.php?id=34&tx_ttnews%5Btt_news%5D=172&cHash=9b703048f84ed32f9b9231a04655d174

WHAT MUST BE DONE

Richard's Bird's Eye Overview of Comparisons of Some Key Status and Service Indicators

- U.S. is the “only” country without a commitment to UHC
- Highest share of uninsured of any high-income country
- Highest costs, relatively low life expectancy
- Unique causes of high mortality such as gun violence and opioids, with almost uniquely declining life expectancy
- A laggard in some key service indicators, even compared to some LMICs
- Key health status indicators are poor compared to peers and even some middle-income countries
- Off the chart (bad) compared to best practice in ethical priority setting for investing in health

Learning from Others (and Ourselves) – What Must We Do?

- Focus on how to achieve UHC as fast as possible, at least cost, in doable, sustainable, and fair ways
- Engage in ethical priority setting
- Brutally cut costs .. by spending more wisely, negotiating at every turn, reducing administrative costs, etc.
- Address the social determinants in least cost and fair ways
- **A public health approach to gun violence**
- **A public health approach to opioids**
- **See gaps in IMR and MMR between us and other HICs as inexcusable and unacceptable**

What are some of the real-world constraints?

- Privately financed elections, with no limits on financing
- Gerrymandering
- American “individualism”, social Darwinism, and antagonism to communitarianism
- American arrogance and ignorance
- A profit-oriented health system with key actors fighting for the spoils – at the expense of consumers

What can be done to enable change?

- State led efforts on UHC
- Locally led efforts on specific gaps
- Private sector led efforts to selectively improve the system and reduce costs
- Philanthropist led efforts on creating and funding “movements” for UHC and addressing key gaps and inequities
- Vote for politicians who understand and care about the ethical and economic value of UHC

Thanks

Thanks to Mary Gaul for assistance in preparing the presentation and to Mary and Lindsey Hiebert, Dr. Antony Measham, Prof. Richard Southby, and Diksha Brahmhatt for their valuable comments on the presentation

Also, special thanks to Coursera for allowing the repurposing of slides from my online course, *Global Health 101*